Simmonds and Hunt: Some Aspects of Chronic Bronchitis

Proceedings of a symposium held at the ~~Reg.~~ Royal Soc. of Medicine London, Nov. 1963.

This is an 87 page monograph consisting of a dozen separate lectures on practically all aspects of chronic bronchitis, namely:

Epidemiology: by D. D. Reid; Natural History by J. Fry. Social aspects by M. Coltart. Pathology, Dr. Lynne Reid. Infective Etiology, M.Calder. Functional disturbances, C. M. Fletcher. Chronic Bronchitis and Occupation, R. E. Lane. Health Education in Respiratory Diseases, A. J. D. Ward. Anti-smoking Clinic, K. P. Ball. Antibiotic Treatment, L. P. Garrod. Antibiotics in Chronic Bronchitic, R. S. Francis. Home Management of Chronic Bronchitis, I. Gregg. Treatment of Advanced Dis., E.J.M. Campbell. These lectures were delivered in four sessions of the Society and each was followed by discussion of the topic by a panel of physicians.

The following are significant statements of special interest to us from some of the lectures listed above.

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D. D. Reid, under the title, Chronic Bronchitis - a British Disease, raises the question, are higher mortality rates in Great Britain a fact or artifact? Are the British more bronchitic or is diagnosis made here more often while neglected elsewhere. He refers to work done by him with D. M. Ferris and Anderson (U.S.A.) using the same questionnaire and Wright Pealflow meter tests in a survey in New Hampshire. Comparing this with survey of College of Gen. Practitioners on about 2000 patients in both surveys 3 factors of importance appeared: age, smoking, type of area, in this order

"Among younger middle aged men difference between nonsmokers and smokers is greatest for simple respiratory symptoms (morning

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phlegm production)."

"As severity of symptoms increase gap between smokers and exsmokers tends to close, probably because those with symptoms have become exsmokers."

"Over age 55 this shift becomes more evident and the non-smokers begin to report symptoms. As a result frequency of respiratory disturbances tends to become similar in the three smoking groups.

Simple bronchitis (chronic cough and phlegm production) differs little among young men and women in the two countries. On the other hand the British rates in older people of both sexes are certainly above the American levels. The difference in disease experience between the countries is most marked however in the relative frequency of the complex form of bronchitis involving repeated chest illness and disabling breathlessness especially in men of 55 or more.

Some of the difference between the two groups can be explained by international differences in smoking habits. If however prevalence rates for complex syndrome are adjusted to take differences in age and life time cigarette consumption into acoount, American rates in both sexes are about the rates for rural areas in Britain. Moreover there is a steady upward progression in rates for men to a peak in larger cities in this country. Results of Wright Peak Flow meter readings on those with symptoms of the "complex syndrome" also suggest that bronchitis is a more serious condition in this country. Studies in the U.S. and in Scandinavia also go to show that bronchitis is not confined to this country, nevertheless, the disease seems to be particularly common and particularly severe in urban Britain. The reasons are far from

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certain. Until more work on this subject is done, the relevance of the factors suggested (small cigarette stub, smog, cold bedroom, other aspects of social environment) must remain among the great unknowns.

J. Fry.

Conclusion: In my practice chronic bronchitis common and increasingly more prevalent with age. In both sexes prevalence rises steeply after age 60 and occurs more often in men than women (3:2). Chronic bronchitis is by no means rare in elderly women. Smoking a factor in males, only 8% occurs in nonsmokers, but in females 56% of chronic bronchitis found in nonsmokers. Increased prevalence found in lower social groups.

In looking at conditions over the years in this particular practice, majority of cases begin in early midlife and only a very small proportion dated onset in childhood. Chronic bronchitis is really chronic, extending 10-30 years in many instances. Final outcome: 43 died during follow-up, 10-15% became severe invalids, 25% moderately disabled, 25% of those surviving were only slightly disabled.

Questions: Why the difference in smoking habits in male and female bronchitics? Why so many persons remain unaffected functionally, whereas others follow malignant and at times fulminating course.

In discussion: There seems to be 3 possible modes of progression. There are persons who run rapid,malignant course; they are very disabled within a matter of 3-5 years and dead short time later. There is another group at other extreme which just does not seem to get any worse in spite of smoking 40 cigarettes a day in addition to any other hazard. Then there is an intermediate group, whose disability increases gradually. I think malignant group smallest;

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the other two about equal in size. Proportion of severely ~~several~~ disabled persons much higher in males than females.

C. M. Fletcher. Functional Disturbances in Chronic Bronchitis.

This lecture deals chiefly with the difficult differentiations of chronic bronchitis with and without emphysema, including following significant statements:

"When severe airway obstruction has been established in a case of severe bronchitis many people assume that the diagnosis is chronic bronchitis and emphysema, the latter implying severe destruction of lung tissue and not simple overinfection which is of course present in all cases of severe airway obstruction."

"Many people have become aware that a considerable proportion of patients who die of chronic bronchitis with severe airway obstruction are not found to have emphysema at postmortem."

Referring to studies made in London and in Chicago he states "In both places something like 15% of cases have definite emphysema. A similar proportion have almost no emphysema. There remains a large middle group in whom we are uncertain how much emphysema there is.

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"A fascinating problem for the future is to discover what causes the obstruction of the airways. All we know at present is that at some point in the intrapulmonary airways there is a severe obstruction during expiration which prevents getting the air out of the lung. This makes the patient breathless and ultimately kills him.

The second session of this symposium was devoted to a discussion in which Colonel H. W. Phelps presented his observations on

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Tokyo-Yokohama Asthma including following significant statements:

"The patients are normal healthy young soldiers mostly under the age of 35 years who deny ever having had any respiratory disease prior to going to Japan. They are almost all moderate cigarette smokers. Between 1 week and 3 months after arriving in Japan they develop dry hacking persistent cough...Eventually they have to be hospitalized in severe "status asthmaticus" (acute asthmatic attacks with wheezing and difficult breathing).

"Many of them did not improve, actually appeared to progress after they left Japan . . . 43% of these men still have marked airflow obstruction after 3 years and five of them have died apparently an acute respiratory death with at least early emphysema."

"Approximately 6% of the military population stationed in this area were affected as determined by pulmonary function tests."

Interesting statements made by others in the discussion which followed:

Dr. Hopkins: "We all know of occurrence of rhinorrhea in vasomotor rhinitis and we know that in bronchitis you get bronchorrhea to start with which subsequently becomes infected. Perhaps the initial stage should be termed "Bronchosis" instead of bronchitis.

"In conclusion, Dr. Phelps: The patients in our study in Japan had very few eosinophiles in their sputum, which confirmed our view that this was not asthma . . . I believe in fact that they were suffering from chronic bronchitis."

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